

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048778

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12620

FILED JAN 10 1963

VS 300 Rev. 4/59

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DATE AMENDED

1/23/63

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

Bethany

SHOULD READ

New Bethlehem

DOCUMENT

BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		c. CITY OR TOWN <u>St. Louis Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1229 Benton St</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle Last <u>STRASSNER</u>			4. DATE OF DEATH Month <u>DEC.</u> Day <u>31</u> Year <u>1962</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-1887</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>					
13a. FATHER'S NAME <u>Frank Kanstienner</u>			13b. MOTHER'S MAIDEN NAME <u>Mary C. Beckerman</u>			14. NAME OF HUSBAND OR WIFE <u>Dec'd</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Marie Palermo</u>		Address <u>1229 Benton</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute and chronic cor pulmonale</u> DUE TO (b) <u>Pulmonary Embolus</u> DUE TO (c) <u>congestive Heart failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Coronary arteriosclerosis</u>										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)								
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. I attended the deceased from <u>12-29-62</u> to <u>12-31-62</u> and last saw her/him alive on <u>12-31-62</u> Death occurred at <u>12:22 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE <u>M.E. Cozart MD</u> (Degree or title)					22b. ADDRESS <u>1515 LAFAYETTE</u>			22c. DATE SIGNED <u>12-31-62</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)						
<u>Removal</u>		<u>1-3-63</u>		<u>Bethany Cemetery</u>		<u>Bellefontaine Neighbors Mo</u>						
24. FUNERAL DIRECTOR <u>John Skypien Son 534 Riverside Bl.</u>					25. DATE RECD. BY LOCAL REG. <u>DEC-31 1962</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>					

COZART

USE BLACK INK OR TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_ Signed JM Rister  
Signature of Student Embalmer

Licensed Embalmer No. 3980

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

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